

## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

10726

## CERTIFICATE OF DEATH

10693

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Harford</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore, Md</i>		c. LENGTH OF STAY IN 1b <i>2 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore, Maryland</i>		d. STREET ADDRESS <i>1000 N. Charles St., Baltimore, Maryland</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>				e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
3. NAME OF DECEASED (Type or print) <i>John</i>	First	Middle	Last	4. DATE OF DEATH <i>Blackburn, Oct 19, 1957</i>	Month	Day	Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 8, 1886</i>	AGE (In years Just birthday) yrs. <i>71</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Janitor on ship yard</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>ash Co., Md.</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>233-22-0739</i>		17. INFORMANT <i>Mrs. Geo Blackburn</i>		Address <i>200 N. Charles St., Baltimore, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Generalized Arterio Sclerosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>Coop</i>		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1000 N. Charles St., Baltimore, Md.</i>	20f. (City, or town) <i>Baltimore, Md.</i>	(County) <i>Baltimore Co., Md.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>May</i> , 19 <i>47</i> , to <i>Oct</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Oct 12, 1957</i> , and that death occurred at <i>1000 N. Charles St., Baltimore, Md.</i> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Baltimore, Md.</i>		DATE SIGNED <i>Oct 21, 1957</i>
ACTUAL SIGNATURE <i>Dulcie Phillips</i>		M.D.						
PHYSICIAN'S NAME (Type) <i>Dulcie Phillips</i>								
22a. PURATION-CREMATION REMOVAL (Specify) <i>removal</i>	22b. DATE THEREOF <i>Oct 20, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Baptist Home, N. Charles St., Baltimore, Md.</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. S. Bailey</i>		ADDRESS <i>1000 N. Charles St., Baltimore, Md.</i>		24a. REC'D BY REGISTRAR <i>Oct 21, 1957</i>		24b. REGISTRAR'S SIGNATURE <i>C. H. Kirk</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**RECEIVED**

OCT 24 1957

**BUREAU X-14**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10693

## CERTIFICATE OF DEATH

10694

Reg. Dist. No.

185-

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVRE DE GRACE</b>		c. LENGTH OF STAY IN lb <b>1 1/2 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MARTHA</b>		First <b>Amelia</b>	Middle <b>Boulden</b>		
4. DATE OF DEATH <b>Oct. 10, 1879</b>		Month <b>October</b>	Day Year <b>6 1957</b>		
S. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 10, 1879</b>		
9. AGE (In years lost birthday) <b>79 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>HENRY GALLION</b>	14. MOTHER'S MAIDEN NAME <b>Averilla Wright</b>	Address <b>Clarendon, Boulden, Perryville, Md</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Clarendon, Boulden, Perryville, Md</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis</b> DUE TO <b>576x</b> Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause last. <b>Unknown</b> DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Anteriosclerotic Cardiovascular disease</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>211 N. Union Ave.</b>	20f. (City or town) <b>Port Deposit, Md.</b>	(County) <b>Rural</b>	(State) <b>MD</b>
21. I certify that I attended the deceased from <b>Oct. 4th</b> , 1957, to <b>Oct. 6th</b> , 1957, that I last saw the deceased alive on <b>Oct. 6th</b> , 1957, and that death occurred at <b>3:31 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Edward C. Foo, M.D.</b>	ADDRESS (Street, city or town, state) <b>211 N. Union Ave., Havre de Grace, Md.</b>		DATE SIGNED <b>Oct. 6th, 1957</b>		
22g. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 10-8-1957</b>	22h. DATE THEREOF <b>10-8-1957</b>	22i. NAME OF CEMETERY OR CREMATORIAL <b>Hopewell</b>	22j. LOCATION (City, town, or county) <b>Port Deposit, Md., Rural</b>	(State) <b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leila Patterson, Perryville, Md.</b>	ADDRESS <b>Leila Patterson, Perryville, Md.</b>	24a. REC'D BY REGISTRAR DATE 10-8-57	24b. REGISTRAR'S SIGNATURE <b>A. L. Dennis, M.D.</b>		

RECEIVED BY MAIL - PARIS - FRANCE - 11

RECEIVED BY AIR - PARIS - FRANCE - 11

BUREAU Y.

OCT 9 1957

RECEIVED

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10695

## 10694 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 182

## 1. PLACE OF DEATH

a. COUNTY

Harford MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bel Air 1 day

c. LENGTH OF STAY IN 1b

Bel Air

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Sturgill's, Rd 1 Bel Air MD RD 1

## 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Md.

b. COUNTY

Harford

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bel Air

## d. STREET ADDRESS

111-111

## e. IS RESIDENCE ON A FARM?

YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATHOctober  
10Year  
1957

## 5. SEX

M

## 6. COLOR OR RACE

W

## 7. MARRIED

## NEVER MARRIED

## 8. DATE OF BIRTH

Sept 26, 1957

9. AGE (In years  
from birthday)

14

## 10. IF UNDER 1 YEAR

Months

Days

## 11. IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

## 10b. KIND OF BUSINESS OR INDUSTRY

## 11. BIRTHPLACE (State or foreign country)

Sparta Md.

## 12. CITIZEN OF WHAT COUNTRY?

U.S.

## 13. FATHER'S NAME

Gladys Brinegar

## 14. MOTHER'S MAIDEN NAME

Frances Crouse

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

(If yes, give rank or dates of service)

## 16. SOCIAL SECURITY NO.

✓

## 17. INFORMANT

Mr. Gladys Brinegar 1340 Pontiac Ave.  
Baltimore 25, Md.

Address

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

391.2

Septicemia

INTERVAL BETWEEN  
ONSET AND DEATH

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), starting the underlying  
cause first.

(b)

DUE TO

(c)

Otitis Media

-

## MEDICAL CERTIFICATION

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Congenital heart disease

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH.

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Month, Day, Year  
Hour  
a. m.  
p. m.20d. INJURY OCCURRED  
While  
at work  Not while  
at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

## 20f. (City or town)

## (County)

## (State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes ; Accident , Suicide , Homicide , Undetermined manner ACTUAL  
SIGNATURE  
GERALD C PALMERM.D. CHIEF MEDICAL EXAMINER  (10-10-57) DATE SIGNEDEXAMINER'S  
NAME (Type)  
GERALD C PALMERASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER 

Baltimore, Md.

22a. BURIAL, CREMATION, REMOVAL (specify)  
Burial22b. DATE THEREOF  
Oct 11, 195722c. NAME OF CEMETERY OR CREMATORY  
New Haven Cemetery22d. LOCATION (City, town, or county)  
Sparta Md.

(State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS  
Broadway + Williams StreetsJoseph Foster  
Bel Air, Maryland24a. REC'D BY REGISTRAR  
DATE 10-11-5724b. REGISTRAR'S SIGNATURE  
Fusilla Lowood

**RECEIVED**

OCT 15 1957

**BUREAU V. 2**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10695

## CERTIFICATE OF DEATH

Reg. Dist. No.

10695  
183

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>HARFORD</i>				a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Havre de Grace</i>				<i>Havre de Grace</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>HARFORD Memorial Hospital</i>		<i>512 Lewis St.</i>			

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
<i>Marshall</i>	<i>James</i>	<i>Carter</i>		<i>Oct</i>	<i>17</i>	<i>1957</i>	

5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS			
<i>Male</i>	<i>Colored</i>	<i>WIDOWED</i> <input type="checkbox"/>	<i>Divorced</i> <input type="checkbox"/>	<i>Sept. 15, 1889</i>	<i>68 yrs.</i>	<i>Months</i>	<i>Days</i>	<i>Hours</i>	<i>Min.</i>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<i>Retired</i>	<i>Carpenter</i>	<i>N.C.</i>	<i>U. S. A.</i>

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
<i>John Carter</i>	<i>Meekie Neely</i>

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address <i>512 Lewis St.</i>
<i>No</i>	<i>237-14-0190</i>	<i>Jennie Carter - Havre de Grace, Md.</i>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		
<i>Cerebral Apoplexia</i>		
334X DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost.		
(b) <i>Hypertension</i>		
DUE TO		
(c) <i>Atherosclerosis</i>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
<i>Oct. 16, 1957</i>	<i>19</i>	<i>Salisbury</i>

21. I certify that I attended the deceased from <i>Oct. 16, 1957</i> to <i>Oct. 17, 1957</i> , that I last saw the deceased alive on <i>Oct. 17, 1957</i> , and that death occurred at <i>9:30 P.M.</i> from the causes and on the date stated above.	ADDRESS (Street, city or town, state)	DATE SIGNED
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ACTUAL SIGNATURE <i>Gauthier D. Hirsch</i>	M.D. <i>421 Congress Ave. Havre de Grace</i>	
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PHYSICIAN'S NAME (Type) <i>Gauthier D. Hirsch</i>	421 CONGRESS AVE. - HAVRE DE GRACE, MD.
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22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	22b. DATE THEREOF <i>Oct. 20, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Methodist Cemetery</i>	22d. LOCATION (City, town, or county) <i>Salisbury</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Otis J. Bullock, Havre de Grace, Md.</i>	ADDRESS <i>512 Lewis St.</i>	24a. REC'D BY REGISTRAR <i>10-30-57</i>	24b. REGISTRAR'S SIGNATURE <i>A.L. Lewis M.D.</i>
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COLLECTORATE OF DEATH

BUREAU V. S.  
RECEIVED  
OCT 22 1957

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-5 10W

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10697

10727

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Harford Rural	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Bel Air	10 1	STREET ADDRESS (If rural give location)
Harford Convalescent Home			
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE OF DEATH</b>	
(First) O'Gello		(Middle) Chamberlain (Last)	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED / DIVORCED, (Specify)	8. DATE OF BIRTH Fidow Jan. 31, 1871
9. AGE last birthday 76 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Housework at home	
13. FATHER'S NAME Columbus Scarborough		11. BIRTHPLACE (State or foreign country) Harford Co., Md., U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) No		16. SOCIAL SECURITY NO. Mrs	
17. INFORMANT & ADDRESS Mrs Jessie E. Scarborough		14. MOTHER'S MAIDEN NAME	
<b>II DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			
153X IMMEDIATE CAUSE (A) Carcinoma of the transverse colon			
ANTECEDENT CAUSES(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
DUE TO (B) None			
DUE TO (C)			
<b>III OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH ?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
<b>22. I hereby certify that I attended the deceased from July 1, 1957, to October 2, 1957, that I last saw the deceased alive on October 1, 1957, and that death occurred at M, from the causes and on the date stated above.</b>			
SIGNATURE Willard P. Hudson		ADDRESS (Street, city, town, state) Forest Hill 10/3/57 Md	
DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial Oct. 6, 1957		DATE THEREOF Emory Cem M.D.	
24. REC'D BY REGISTRAR DATE Oct. 5, 1957		REGISTRAR'S SIGNATURE C.W. Kirk	
25. FUNERAL DIRECTOR'S SIGNATURE H. Bailey		ADDRESS Parlington Md	

STATE OF TEXAS - DEPARTMENT OF PUBLIC SAFETY

CERTIFICATE OF DEATH

DEATH CERTIFICATE

BUREAU V. S.

OCT 14 1957

RECEIVED

FOR STATE  
HEALTH DERT.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. ATSM  
6M 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10696 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10698

Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Md</i> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aurora de bruce</i>		c. LENGTH OF STAY IN Tb —	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>DOA Harford Memorial Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. STREET ADDRESS <i>25th St.</i>		f. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>James T. Cint</i>		4. DATE OF DEATH Month <i>October</i> Day <i>20</i> Year <i>1957</i>	5. SEX <i>M</i> 6. COLOR OR RACE <i>W</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>May, 6, 1922</i>		9. AGE (In years In months)	10. IF UNDER 1 YEAR Months <i>35</i> Days <i>35</i> Hours <i>1</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tool Crib Att.,</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bendix Radio</i>	11. BIRTHPLACE (State or foreign country) <i>Champaign, Ill.,</i>
13. FATHER'S NAME <i>Virgil Cint</i>		14. MOTHER'S MAIDEN NAME <i>Mildred</i> ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>347-12-9081</i>	17. INFORMANT Address <i>Viola Cint, 35 E. 25th St., Baltimore, Md.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>Fracture skull, compound, comminuted</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Auto accident, auto - auto type</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Auto accident, auto - auto type</i>	
20c. TIME OF INJURY Month, Day, Year <i>12:55 p.m. 10-20 1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <i>Route 40</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Edgar Hwy 40, Harford Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. ACTUAL SIGNATURE <i>Gerald E Palmer</i> DATE SIGNED <i>10-20-57</i>	
EXAMINER'S NAME (Type) <i>Gerald E Palmer MD</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <i>removal</i>		22b. DATE THEREOF <i>Oct. 20, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Owens Funeral Home,</i>		22d. LOCATION (City, town, or county) <i>Champaign, Champaign, Ill.,</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard K. McComas Jr.</i>		ADDRESS <i>Abingdon, Md.</i>	
		24a. REC'D BY REGISTRAR DATE <i>Oct 20 1957</i>	
		24b. REGISTRAR'S SIGNATURE <i>Dr. A. L. Lewis</i>	

YUNEAU Y. E.

1057

REVIEW

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10697 CERTIFICATE OF DEATH

10699  
185

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 2, which should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY HARFORD		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY HARFORD		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVE DE GRACE		c. LENGTH OF STAY IN 1b 3 DAYS 9 HRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITE HALL				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD VETERINARY HOSPITAL		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JAMES WILLEY COX		First	Middle	Last	4. DATE OF DEATH	Month OCTOBER	Day 21	Year 1957
S. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH DEC 21 1880	9. AGE (in years lost birthday) 58 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) GROCERY STORE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME WILLIAM DAVID COX		14. MOTHER'S MAIDEN NAME unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT ZOE A. COX (wife) WHITE HALL, MD.		Address		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Central Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.		
(b)		DUE TO		Hypertension Arteriosclerosis		1 year		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from 10/16/57, 1957, to 10/20/57, 1957, that I last saw the deceased alive on 10/20/57, 1957, and that death occurred at 5:45 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED 10/21/57
ACTUAL SIGNATURE IRVING WACHSMAN								
PHYSICIAN'S NAME (Type) IRVING WACHSMAN								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-23-57		22c. NAME OF CEMETERY OR CREMATORIUM NEW BETHEL BAPTIST		22d. LOCATION (City, town, or county) HOPEWELL TWP. YORK CO. PA.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Wachsmann Stewartstown, Penna.		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 25 1957		24b. REGISTRAR'S SIGNATURE A. L. Livingston		

RECEIVED  
BUREAU V. S.

OCT 2 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10700

10728

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MD b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAVRE DE GRACE		c. CITY OR TOWN (If, outside corporate limits, write RURAL and give nearest town) RURAL HAVRE DE GRACE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RD #2		d. STREET ADDRESS RD #2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JAMES	Middle M.	Last DE BONIS
4. DATE OF DEATH Oct 7 1957	Month	Day	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 1, 1888
9. AGE (in years last birthday) 69 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANK DE BONIS		14. MOTHER'S MAIDEN NAME ELIZABETH UNK.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 17. INFORMANT PEARL H. DE BONIS, HAVRE DE GRACE, RD #2 Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH, if known	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary thrombosis		4 -	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease		4 -	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957 to 1957, that I last saw the deceased alive on 10/1/1957, and that death occurred at 8:33 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Aberdeen, Md. DATE SIGNED 10/8/57			
ACTUAL SIGNATURE F. J. Haten M.D.			
PHYSICIAN'S NAME (Type)		Aberdeen - Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Oct 11, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL BEL AIR MEMORIAL Gardens		22d. LOCATION (City, town, or county) BEL AIR, MD (State)	
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE 10-11-57	
		24b. REGISTRAR'S SIGNATURE G. L. Lewis, Md.	

**TO PHYSICIAN OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU

OCT 14 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10701

10698

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD DE GRACE LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD DE GRACE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 722 GREEN ST		d. STREET ADDRESS 722 GREEN ST	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CARROLL WATTS	Middle DEANIS	4. DATE OF DEATH Oct 31 1957
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 26, 1882
9. AGE (In years last birthday) 75 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DENNIS		14. MOTHER'S MAIDEN NAME ALICE MITCHELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		17. INFORMANT Mrs. ANNA ARMSTRONG HARFORD DE GRACE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  4 hours DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  (b) DUE TO  (c)		Acute Pulmonary Edema Atherosclerotic Heart Disease	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 19, 1956, to Oct. 31, 1957, that I last saw the deceased alive on 10/26, 1957, and that death occurred at 3:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE F. J. Haten		ADDRESS (Street, city or town, state) 17 N. Phila. Rd. Aberdeen, Md.	
PHYSICIAN'S NAME (Type) F. J. Haten		DATE SIGNED 11/15/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Nov. 3, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Rock Run		22d. LOCATION (City, town, or county) (State) HARFORD MD	
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell Harford Co., Md.		24a. REC'D BY REGISTRAR DATE 11-4-57	
		24b. REGISTRAR'S SIGNATURE A. L. Henrich, M.D.	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10702

10729

## CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH o COUNTY  Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belcamp Rural		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Charles Edward	Middle Dickson
4. DATE OF DEATH	Month Oct.	Day 8,	Year 1957
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 25, 1871
9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Owner	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY, U.S.A.			
13. FATHER'S NAME David Dickson		14. MOTHER'S MAIDEN NAME Nancy Kerr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Robert Dickson, Address Bel Air R.D., Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio - atherosclerotic disease		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma lung - secondary metastases		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>Oct</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Oct 7</u> , 19 <u>57</u> and that death occurred at <u>6 P. M.</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Ralph Horley</u> PHYSICIAN'S NAME (Type) <u>T. Ralph Horley</u>		ADDRESS (Street, city or town, state) Churchville DATE SIGNED <u>Oct 10</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 11, 1957	22c. NAME OF CEMETERY OR CREMATORI St. Francis	22d. LOCATION (City, town, or county) Abingdon, Harford, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard W. Lewis</u>	ADDRESS Abingdon, Md.	24a. REC'D. BY REGISTRAR DATE Oct. 11, 1957	24b. REGISTRAR'S SIGNATURE <u>Norma G. Moore</u>

BUREAU V. S.

OCT 14 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10730

## CERTIFICATE OF DEATH

10703

Reg. Dist. No. 180

Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

To Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Hartford</i>		2. USUAL RESIDENCE (Where deceased lived) b. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Joppa</i>		c. LENGTH OF STAY IN 1b <i>2 yrs.-</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Beckord Rd.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Joppa</i>	
f. STREET ADDRESS <i>Beckord Rd.</i>		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Charles M. Diven</i>		First	Middle
4. DATE OF DEATH <i>October 24, 1957</i>		Last	Month Day Year
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 1, 1884</i>
9. AGE (In years to nearest birthday) <i>73 yrs.</i>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Blacksmith.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Blacksmithing</i>	
10c. BIRTHPLACE (State or foreign country) <i>Baltimore Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas H. Diven</i>		14. MOTHER'S MAIDEN NAME <i>A Mary Resh</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>                        </i>	
17. INFORMANT <i>Mrs. Andrew Mayer, Joppa, Md. R.D.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
		Cerebral Gliomobasis (3 <sup>rd</sup> ), Hypertension. Cardiomas. Dis	
		3 days. 10 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>                        </i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>                        </i>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) <i>Fork, Md.</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4/13</i> , 19 <i>33</i> , to <i>10/24</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>10/23</i> , 19 <i>57</i> , and that death occurred at <i>10:30 AM</i> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Fork, Md.</i> DATE SIGNED <i>Clifford F. Hudson</i>	
ACTUAL SIGNATURE <i>Clifford F. Hudson</i>		PHYSICIAN'S NAME (Type) <i>CLIFFORD F. HUDSON, FORK, MD.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 27 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Emmetsburg Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Glen Rock P. R.D.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Daryl Hartenstein, New Franklin</i>		24a. ADDRESS <i>                        </i>	
24b. REC'D BY REGISTRAR <i>                        </i>		24c. REGISTRAR'S SIGNATURE <i>Norma Moore</i>	

BUREAU Y. S.

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RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for us as a burial transit permit.

VII A15C 1-55 10/11

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10704

Reg. Dist. No. 182

## CERTIFICATE OF DEATH

10731

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town)	HARFORD		MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town)	Md		COUNTY TOWN STREET ADDRESS
TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS			94 yrs	TOWN High Point Road			High Point Road Forest Hill Md
<b>3. NAME OF DECEASED</b> (Type or Print)				(First) LESSIE JANE DUNCAN	(Middle)	(Last)	<b>4. DATE OF DEATH</b> Oct 19 1957
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH July 14 1896 61	9. AGE last birthday 11 19	10. IF UNDER 1 YEAR Months 11	11. IF UNDER 24 HRS Days 19	12. IF UNDER 24 HRS Hours 00 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Calvin Cheek				14. MOTHER'S MAIDEN NAME Enniece Johnson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. 215-32-9685			
17. INFORMANT & ADDRESS Franklin M. Duncan				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE <input checked="" type="checkbox"/>		(A) DUE TO ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		PULMONARY EDEMA		INSTANT	
		(B) DUE TO		CONGESTIVE HEART FAILURE		OVER 1 YR	
		(C) DUE TO		ARTERIO-SCHEROTIC CARDIOVASCULAR DISEASE		OVER 1 YR	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) Bel Air Md		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from MAX 1957 to OCT 19, 1957, that I last saw the deceased alive on OCT 13, 1957, and that death occurred at 3:40 P.M. from the causes and on the date stated above.				ADDRESS (Street, city, town, state)			
SIGNATURE Philip W. Hansen M.D.				DATE SIGNED Oct 19 1957			
23. BURIAL, CREMATION REMOVAL (SPECIFY) Burial		DATE THEREOF Oct 22 57		NAME OF CEMETERY OR CREMATORIAL Bel Air Memorial Gardens Bel Air Md.		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE Date 10-22-57				25. FUNERAL DIRECTOR'S SIGNATURE Martin E. Frantz, Jr. Funeral Director		ADDRESS	

RECEIVED

OCT 24 1961

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10705

10699

## CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HARVE DE GRACE</b>		c. LENGTH OF STAY IN 1b <b>3 HRS 23 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RISING SUN</b>		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL HOSPITAL</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Frank</b>		First <b>Frank</b>	Middle <b>Edwin</b>	Last <b>ECCLES</b>	4. DATE OF DEATH <b>OCTOBER 25 1957</b>	Month <b>OCTOBER</b>	Day <b>25</b>	Year <b>1957</b>	
S. SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 25, 1937</b>	9. AGE (In years lost birthday) yrs <b>20</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. Hours <b>0</b>	13. Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>ROBERT WILLIAM ECCLES</b>		14. MOTHER'S MAIDEN NAME <b>BEATRICE DALEY</b>		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity - Infant</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>RISING SUN, MD.</b>		20f. (City or town) (County) <b>RISING SUN</b>		(State) <b>MD.</b>	
21. I certify that I attended the deceased from <b>10/25/57</b> to <b>10/25/57</b> , that I last saw the deceased alive on <b>10/25/57</b> , and that death occurred at <b>11:30 PM</b> , from the causes and on the date stated above.		ACTUAL SIGNATURE <b>Neil Taylor Jr.</b>		M.D.		ADDRESS (Street, city or town, state) <b>RISING SUN, MD.</b>		DATE SIGNED <b>10/25/57</b>	
22a. BURIAL/CREMATION REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>10-25-57</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>HARFORD MEMORIAL HOSPITAL</b>		22d. LOCATION (City, town, or county) <b>HARVE DE GRACE, MD.</b>		(State) <b>MD.</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>Harve de Grace Administration</b>		ADDRESS <b>714 1/2</b>		24a. REC'D BY REGISTRAR <b>DATE 11-1-57</b>		24b. REGISTRAR'S SIGNATURE <b>G. L. Lewis M.D.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial permit. Then please remove carbon paper. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)  
1SM 9/55

PUREAU N.Y.C.

NOV 4 1957

REGISTRY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10706

10700

## CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY		HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		MD.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY		HARFORD		
Harve-de-Grace		1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		BEL AIR		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		RD #3		
Harford Memorial Hospital								
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Hannah				Ellen EVERITT	Oct 5	10	6	1957
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (in years lost birthday) yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
Female White				Oct 5 1888		69		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
House-wife				Md.		US		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
Iris George		ESTELLE Patterson						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or never) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
		✓		WMP Everett Bel Air Md				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		CORONARY OCCLUSION		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.		
		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Arteriosclerosis Generalized		3 months		
		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		URINARY INCONTINENCE, TUMOUR OF U. BLADDER				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____, from the causes and on the date stated above.		Aug. 1953 to Oct. 6, 1957		ADDRESS (Street, city or town, state)		DATE SIGNED		
ACTUAL SIGNATURE A. Sandekian M.D.								
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 8/57		22c. NAME OF CEMETERY OR CREMATORIAL St. Mary's Episcopcal		22d. LOCATION (City, town, or county) EMMERTON ASYLUM MD		(State)
22e. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Faller Bel Air Md		ADDRESS		24a. REC'D BY REGISTRAR OCT 9 1957		24b. REGISTRAR'S SIGNATURE J. O. Lewis		

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
 MEDICAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 9 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10707

185

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		10701	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE <i>Maryland</i>		b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Holy De. Grace</i>		c LENGTH OF STAY IN 16	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Deposit</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Mem. Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Elie</i>	Middle <i>Albert</i>	Last <i>Ewing</i>	4. DATE OF DEATH <i>October 17</i>	Month Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>12-9-02</i>	9. AGE (in years last birthday) <i>54 yrs.</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Crippled</i>		11. BIRTHPLACE (State or foreign country) <i>Penns.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Emard Elie Ewing</i>		14. MOTHER'S MAIDEN NAME <i>Lena May Johnson</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>Q73</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Ruth Martin</i>		Address <i>Port Deposit Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  <i>Diabetes Mellitus - uncontrolled.</i>						INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs.</i>
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.  <i>(b)</i>		DUE TO				
 <i>(c)</i>		DUE TO				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Rising Sun, Md.</i>	(County) <i>Rising Sun, Md.</i>	(State) <i>Rising Sun, Md.</i>
21. I certify that I attended the deceased from <i>Oct 14</i> , 19 <i>57</i> to <i>Oct 17</i> , 19 <i>57</i> that I last saw the deceased alive on <i>Oct 17</i> , 19 <i>57</i> , and that death occurred at <i>10 p.m.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Neil Taylor Jr.</i> PHYSICIAN'S NAME (Type) <i>Neil Taylor Jr.</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 20/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Hopewell Cem</i>	22d. LOCATION (City, town, or county) <i>Rising Sun, Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Earl Syson</i>		ADDRESS <i>Rising Sun, Md.</i>	24a. REC'D BY REGISTRAR <i>Dr. J. L. Lewis</i>	24b. REGISTRAR'S SIGNATURE <i>Dr. J. L. Lewis</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V A

OCT 21 1957

REGEIVF

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10702

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10708  
185

Reg. Distr. No.

FOR STATE  
ALTM DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and if any event within 72 hours after death.

## PLACE OF DEATH

a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Harford

c. LENGTH OF STAY IN lb

20 yrs.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

3. NAME OF  
DECEASED  
(Type or print)First  
chester

Middle

Last  
Faltynowicz

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE  
OF BIRTH

11/20/1917

9. AGE (In years  
at birthday)

39 yrs

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HRS

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Curious Human

10b. KIND OF BUSINESS OR INDUSTRY

APL

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Frank Saltynowicz

14. MOTHER'S MAIDEN NAME

Josephine ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

(If yes, give rank or date of service)

W.W. 2

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT

Mrs Theresa Saltynowicz

Address: Robert & Elizabeth St.  
Unknown Name Saltynowicz Hanover, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

973.1

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES  NO INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

Piped auto exhaust fumes into his car

20c. TIME OF INJURY Month, Day, Year

Hour

10-19 1957

20d. INJURY OCCURRED

While at work  Not while at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

Garage

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner 

Actual Signature: Gerald C Palmer

M.D. CHIEF MEDICAL EXAMINER 

DATE SIGNED

EXAMINER'S  
NAME (Type)

Gerald C Palmer

Bel Air, Md.

10-19-57

ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER 22a. BURIAL, CREMATION  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

10/22/57

22c. NAME OF CEMETERY OR CREMATORIUM

Mt. Zion

22d. LOCATION (City, town, or county)

Harford, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Funeral Director: Rev. Hand, Hanover, Md.

ADDRESS

24a. REC'D BY REGISTRAR

10-24-57

24b. REGISTRAR'S SIGNATURE

A.L. Lewis, M.D.

(State)

RECEIVED  
BUREAU V. A.

OCT 25 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10703

## CERTIFICATE OF DEATH

1070ff65

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)  
15M 9/55

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>PENNSYLVANIA</b>		b. COUNTY <b>Lancaster</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVRE DE GRACE</b>		c. LENGTH OF STAY IN 1b <b>2 HRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PEACH bottom</b>		d. STREET ADDRESS <b>Rural</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL Hosp.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>JERRY WAYNE</b>		First	Middle	Last	4. DATE OF DEATH <b>OCTOBER 30 1957</b>	Month	Day	Year
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3-22-1953</b>	9. AGE (In years from birthday) <b>2 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Lancaster Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>DAVID FRANKLIN Flora</b>		14. MOTHER'S MAIDEN NAME <b>MAXINE GENEVA Hamilton</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>David F. Flora Peachbottom, Penn.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tonsillitis laryngitis bronchitis</b> INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rising Sun</b>		20f. (City or town) <b>Rising Sun</b>	(County) <b>Maryland</b>	(State) <b>Maryland</b>
21. I certify that I attended the deceased from <b>10/29/57</b> to <b>10/30/57</b> that I last saw the deceased alive on <b>10/29/57</b> , and that death occurred on <b>10/30/57</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>Neil Taylor Jr.</b> M.D. ADDRESS (Street, city or town, state) <b>Rising Sun Maryland</b> DATE SIGNED <b>10/31/57</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial 10/31/57</b>		22b. DATE THEREOF <b>10/31/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Penn Hill Cemetery Quarryville Pa.</b>		22d. LOCATION (City, town, or county) (State) <b>Quarryville Pa.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gail Tyson Rising Sun Md.</b>		ADDRESS <b>Rising Sun Md.</b>		24a. REC'D BY REGISTRAR DATE <b>1957</b>		24b. REGISTRAR'S SIGNATURE <b>Gail Tyson</b>		

BUREAU V. S.

NOV 4 1957

REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

107181

Reg. Dist. No.

10732

1. PLACE OF DEATH  
a. COUNTY

Hagerstown

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE MD

b. COUNTY Hagerstown

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Perryman

c. LENGTH OF STAY IN 1b

8 years

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Perryman

d. STREET ADDRESS

Winterspoon's Trailer Park

e. IS RESIDENCE  
ON A FARM  
YES  NO

3. NAME OF

(Type or print)

First

Middle

Last

William C. Foreman

4. DATE  
OF  
DEATH

Month  
October

Day  
17

Year  
1957

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

4/7/1943

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

10b. KIND OF BUSINESS OR INDUSTRY

School

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Albert C. Foreman

14. MOTHER'S MAIDEN NAME

Lillian M. Harrel

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

G.S.W. R. chest

7.0

DUE TO

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause first.

(b)

DUE TO

(c)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING

CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

Accidental shot with shot gun

20c. TIME OF INJURY

Month, Day, Year

Hour

5 p.m.

10-7 1957

While at work  Not while at work

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

Hagerstown

(County)

(State)

Hagerstown Md.

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined manner

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

Gerald C. Palmer

Gerald C. Palmer

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Bell Air  
Md.

DATE SIGNED

10-8-57

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

10/11/1957

22c. NAME OF CEMETERY OR CREMATORIUM

Bell Air Memorial Gardens

22d. LOCATION (City, town, or county)

Bell Air Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

John G. Farren

ADDRESS

oberdean rd.

24a. REC'D. BY REGISTRAR

Dec 11-57

24b. REGISTRAR'S SIGNATURE

Hellie R. Perry

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMA3. Page 5 may be retained by the Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VISITORS  
SM 2'57

BURRILL

OCT 14 1955

RECEIVED

X1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

10711  
185

Reg. Dist. No.  
185

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be given to the Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>Md</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harrowe do Grace</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dot Harford Memorial Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. STREET ADDRESS <b>Fort Holabird</b>		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>H. J. - 24</b>	Middle <b>E</b>	4. DATE OF DEATH <b>October 20</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/19/1925</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USA</b>	
10c. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		11. AGE (In years less than today) <b>32 yrs</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Clara (unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>145-18-0663</b>	
17. INFORMANT <b>Quartermaster Dept. AFM 2nd</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Fracture skull</b>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  DUE TO  (b)  DUE TO  (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  20c. TIME OF INJURY Hour <b>1205</b> Month, Day, Year <b>10-20 1957</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Auto accident auto - auto type</b>	
20d. INJURY OCCURRED at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>US Route 40</b>	
20f. (City or town) <b>Edgewood</b>		(County) <b>Hager</b> (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Gerald E. Palmer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Gerald E. Palmer MD</b>		DATE SIGNED <b>8th Apr, 1957</b>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>10/22/1957</b>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Aberdeen</b>		22d. LOCATION (City, town, or county) <b>Franklin New Jersey</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Carrigan Aberdeen Md.</b>		24a. REC'D BY REGISTRAR DATE <b>10/24/57</b>	
		24b. REGISTRAR'S SIGNATURE <b>A. L. Lewis Jr. L.</b>	

BUREAU V. S.

OCT 25 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10705 10,712

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 11. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMI. Page 5 may be retained for files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains prior to burial; cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Harford MARYLAND		a. STATE Md b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dartford Memorial Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH October 9 Year 1957	
Ronald Spencer Grueninger		First	Middle
5. SEX M		6. COLOR OR FACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 3-18-39	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labourer		10b. KIND OF BUSINESS OR INDUSTRY BUILDING	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lyell Ed. Grueninger		14. MOTHER'S MAIDEN NAME MILDRED STEINER ELLIOTT Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 217-364733 17. INFORMANT Lyell E. Grueninger, Havre de Grace, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture skull, compound 816x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Fracture R leg.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident, auto-object-type	
20c. TIME OF INJURY Month, Day, Year Hour p.m. 10-9-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Riverside Garage - Md (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Gerald C. Palmer EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Bel Air, Md 10-9-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 13, 1957	
22c. NAME OF CEMETERY OR CREMATORIAL Angel Hill		22d. LOCATION (City, town, or county) HAVRE DE GRACE (State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell HAVRE DE GRACE, MD		ADDRESS	
		24a. REC'D BY REGISTRAR DATE 10-14-57	
		24b. REGISTRAR'S SIGNATURE A. L. Henry, M.D.	

BUZAEV V. S

1900 - 1901

БУЗАЕВ

FOR STATE  
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be used for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
BM 2/25

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10706 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G222 10-29-57 et

10713

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)	
<i>Harford</i>		a. STATE <i>Md</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore de Grace</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>DOA Harford Mental Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Mary's Hospital</i>	
3. NAME OF DECEASED (Type or print) <i>Cly, 55 Harford Franklin Hash</i>		f. STREET ADDRESS RD. 2 Bel Air	
3. NAME OF DECEASED (Type or print) <i>Cly, 55 Harford Franklin Hash</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. SEX <i>M</i>	5. COLOR OR RACE <i>W</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>5-19-39</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Building &amp; Construction</i>	
10c. BIRTHPLACE (State or foreign country) <i>Maryland</i>		11. AGE (In years from birthday) <i>18 yrs</i>	
13. FATHER'S NAME <i>Glenn Hash</i>		14. MOTHER'S MAIDEN NAME <i>Mary Long</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Glenn Hash</i>		18. DATE OF DEATH <i>October 18 1957</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture skull committed, compound.</i> DUE TO <i>819X</i> Conditions, if any, which gave rise to immediate cause (b) <i>(b)</i> DUE TO <i>(c)</i>		Address <i>R.D. 2 Bel Air, Md.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? <i>Yes <input type="checkbox"/> No <input type="checkbox"/></i>		INTERVAL BETWEEN ONSET AND DEATH <i>—</i>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18+) <i>Auto accident auto-object type</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>3 p.m.</i> Month <i>10-18</i> Day <i>1957</i>		20d. INJURY OCCURRED While <i>at work</i> Not while <i>at work</i>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Bush X</i>		20f. (City or town) <i>Pylesville Harford</i> (County) <i>Md</i> (State) <i>—</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer AD</i>		DATE SIGNED <i>Bel Air, Md 10-18-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/21/57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Welcome Home Cemetery</i>		22d. LOCATION (City, town, or county) <i>R.D. Bel Air Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Barringer</i>		24a. REC'D BY REGISTRAR <i>A. L. Lewis M.D.</i> 24b. REGISTRAR'S SIGNATURE <i>A. L. Lewis M.D.</i>	
ADDRESS <i>Aberdeen, Md.</i>		DATE <i>10/24/57</i>	

RECEIVED  
BUREAU V. S.

OCT 25 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10714

10733

## CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH a. COUNTY  Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland		b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Magnolia		c. LENGTH OF STAY IN lb 5 yrs.,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Magnolia				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First William	Middle G.	Last Hueitt	4. DATE OF DEATH Oct. 10, 1957	Month Oct.	Day 10	Year 1957
5. SEX male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1891		9. AGE (in years last birthday) 65 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME Elisha		14. MOTHER'S MAIDEN NAME Elisiah Hueitt						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO ?		17. INFORMANT Samule K. Hueitt, Joppa R.D., Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis						INTERVAL BETWEEN ONSET AND DEATH several hrs.		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Arteriosclerotic cardiovascular disease				many years		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Possible nephritis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. p.m.	Month 19	Day Not while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Bel Air, Md.	(County)	(State)	
21. I certify that I attended the deceased from December 11, 1956, to October 10, 1957, that I last saw the deceased alive on October 1, 1957, and that death occurred at 3:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Paul S. Stonesifer, Jr.								
PHYSICIAN'S NAME (Type) Paul S. Stonesifer, Jr.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 14, 1957		22c. NAME OF CEMETERY OR CREMATORIAL Chestnut Grove		22d. LOCATION (City, town, or county) Rocks, Harford, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Howard W. Morris		ADDRESS Abingdon, Md.		24a. REC'D BY REGISTRAR Oct. 14, 1957		24b. REGISTRAR'S SIGNATURE Norma G. Moore		

BUREAU V. S.

OCT 16 1957

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA2. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the Funeral Board of Health, or its designee or agent. Prior to burial, cremation, or removal, and in any case within 72 hours after death.

FOR STATE  
HEALTH DEPT.

M

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10707 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10715

Reg. Dist. No.

18

1. PLACE OF DEATH a. COUNTY		Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Aberdeen		d. STREET ADDRESS	
c. LENGTH OF STAY IN lb				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		#2 Buchanan Ave.		f. DATE OF DEATH Month Day Year	
3. NAME OF DECEASED (Type or print)		First	Middle	Oct 10 1957	Month Day Year
4. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last b'day) IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Clerk-&-Carpenter		Hardware Store		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
George Johnson		Katherine Holloway		U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-04-9069		17. INFORMANT Mrs. Arthur E. Johnson Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address 2 Buchanan Ave.			
PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH			
Coronary occlusion					
DUE TO					
Conditions, if any, which gave rise to immediate cause (b)					
(c)					
DUE TO					
(d)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Gerald E Palmer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 10-11-57	
EXAMINER'S NAME (Type) Gerald E Palmer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22o. BURIAL/CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/13/57		22c. NAME OF CEMETERY OR CREMATORIAL Spesutia	
22d. LOCATION (City, town, or county) Aberdeen, R.B. Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE John G. Farren		ADDRESS Aberdeen, Md.		24o. REC'D BY REGISTRAR Oct 13/57	
				24b. REGISTRAR'S SIGNATURE Neilia R. Henry	

BUREAU Y. S.

OCT 16 1957

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10708

## CERTIFICATE OF DEATH

Reg. Dist. No.

10716

1. PLACE OF DEATH a. COUNTY <b>Harford</b>			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US Army Hospital</b>			d. STREET ADDRESS <b>401 S. Union Avenue</b>		
			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>Edgar</b>	Middle <b>Elgar</b>	Last <b>King</b>	4. DATE OF DEATH <b>October</b>	Month <b>2</b> Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>January 21, 1917</b>	9. AGE (In years lost birthday) <b>40 yrs</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>	11. BIRTHPLACE (State or foreign country) <b>Oklahoma</b>	12. CITIZEN OF WHAT COUNTRY/ <b>USA</b>
13. FATHER'S NAME <b>John King</b>			14. MOTHER'S MAIDEN NAME <b>Iva Heaton</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>			16. SOCIAL SECURITY NO. <b>446-01-01379</b>	17. INFORMANT <b>Official Army Records, APGm Md.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable acute coronary artery occlusion</b>			INTERVAL BETWEEN ONSET AND DEATH <b>420.1</b>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)  (c)					
DUE TO					
DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>US Army Hospital</b>	20f. (City or town) <b>Aberdeen Proving Ground, Md.</b> (County) <b>Harford</b> (State) <b>Md.</b>
21. I certify that I attended the deceased from <b>October 2</b> , 1957, to <b>October 2</b> , 1957, that I last saw the deceased alive on <b>October 2</b> , 1957, and that death occurred at <b>1105a</b> M, from the causes and on the date stated above.			ADDRESS (Street, city or town, state) <b>US Army Hospital</b> DATE SIGNED <b>Aberdeen Proving Ground, Md. Oct 2, 1957</b>		
ACTUAL SIGNATURE <b>WILLIAM M MICHENER, Capt, MC</b>			M.D.		
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>10/4/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Ranger 80x3</b>	22d. LOCATION (City, town, or county) <b>Ranger 80x3</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Murray when seen rec'd.</b>			24a. REC'D BY REGISTRAR <b>Rec'd 4-5-77</b>	24b. REGISTRAR'S SIGNATURE <b>Willie P. Perry</b>	

BUREAU V. S.

1957

REVIEWED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10709

## CERTIFICATE OF DEATH

Reg. Dist. No. 186

10717

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institutional Residence before admission) b. STATE Penna b. COUNTY Lancaster				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace	c. LENGTH OF STAY IN lb 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Peach bottom 75 x 5	d. STREET ADDRESS RFD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hartford Memorial Hospital	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Nina First V. Middle Knight	4. DATE OF DEATH Month October Day 2 Year 1957					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-27-1896	9. AGE (In years lost birthday) 61 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME William Orr		14. MOTHER'S MAIDEN NAME Mary E. Sampson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO.		17. INFORMANT J. Graham Knight, Peach Bottom, Pa.		Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular thrombosis DUE TO and heron age Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Cardiovascular DUE TO disease (c)						INTERVAL BETWEEN ONSET AND DEATH 2-3 months.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>Sept. 29th, 1957</u> , to <u>Oct. 2nd, 1957</u> , that I last saw the deceased alive on <u>October 2, 1957</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>Edward C. Too, M.D.</u> M.D. <u>211 N. Union Ave.</u> DATE SIGNED <u>10/2/57</u> PHYSICIAN'S NAME (Type) <u>Edward C. Too, M.D.</u> Havre de Grace, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 10-5-1957	22b. DATE THEREOF 10-5-1957	22c. NAME OF CEMETERY OR CREMATORIAL Washington	22d. LOCATION (City, town, or county) Washington, Md.	(State)		
23. FUNERAL DIRECTOR'S SIGNATURE See a. Patterson & Son, Perryville, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE 10-3-57	24b. REGISTRAR'S SIGNATURE A. D. Lewis M.D.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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KELLOGG CO.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, this page could be detached for use as the burial-tranit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 15 thru 222 11-1-57 et

10710

## CERTIFICATE OF DEATH

10718

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	b. COUNTY <b>Harford</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>	c. LENGTH OF STAY IN 1b <b>31</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>	d. STREET ADDRESS <b>626 Brenda Lane</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>626 Brenda Lane</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Walter W. Kollmar</b>	First <b>Walter</b>	Middle <b>W.</b>	Last <b>Kollmar</b>	4. DATE OF DEATH <b>October 24 1957</b>	Month <b>October</b>	Day <b>24</b>	Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 March 1919</b>	9. AGE (in years lost birthday) <b>38 yrs</b>	10. IF UNDER 1 YEAR <b>Months</b>	11. IF UNDER 24 HRS <b>Days</b>	12. IF UNDER 24 HRS <b>Hours</b>	13. IF UNDER 24 HRS <b>Min.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Analyst</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Walter H. Kollmar</b>			14. MOTHER'S MAIDEN NAME <b>Frieda Jungermann</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 2, Korean, 145-03-4100</b>		17. INFORMANT <b>Joshua Kramer</b>		Address <b>Aberdeen, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <b>197.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>June 29, 1957</b> to <b>Oct 24, 1957</b> , that I last saw the deceased alive on <b>Oct 24, 1957</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>617 W. Bel Air Ave. Oct 25, 1957</b>								
ACTUAL SIGNATURE <b>B.J. Plunkett Jr.</b>	M.D.	DATE SIGNED <b>Oct 25, 1957</b>						
PHYSICIAN'S NAME (Type) <b>B.J. Plunkett Jr.</b>	M.D.	22. LOCATION (City, town, or county) <b>Baltimore</b> (State) <b>Maryland</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation 10/28/57</b>	22b. DATE THEREOF <b>10/28/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Greenmount</b>	24a. RECEIVED BY REGISTRAR DATE <b>Oct 28/57</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>John E. Kersey</b>	ADDRESS <b>Aberdeen, Md.</b>	24b. REGISTRAR'S SIGNATURE <b>Nellie R. Perry</b>						

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OCT 22 1957  
K-5-22-1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10719

10711

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
<i>Harford</i> <small>MARYLAND</small>		<i>Maryland</i> <small>HARFORD</small>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Aberdeen</i>	<i>24 yrs.</i>	<i>Aberdeen</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<i>411 Edmund Street</i>	<i>1411 Edmund St.</i>		
3. NAME OF DECEASED (Type or print)	First <i>Joseph</i>	Middle <i>E. Lawson</i>	4. DATE OF DEATH Month 10 Day 3 Year 1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
<i>Male Negro</i>	<i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></i>	<i>3-27-1897</i>	9. AGE (In years last birthday) 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>Barber</i>		<i>Barber</i>	<i>Va.</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Charles Lawson</i>		<i>Isabell Lewis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	17. INFORMANT
		<i>none</i>	<i>Mrs. Mary E. Lawson - Aberdeen, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>6 weeks</i>	
<i>177X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Carcinoma of prostate</i>		<i>5 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>10-3-1957</i> to <i>10-3-1957</i> , that I last saw the deceased alive on <i>10-2-1957</i> , and that death occurred at <i>5:15 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Aberdeen, Md.</i> DATE SIGNED <i>10-4-57</i>	
ACTUAL SIGNATURE <i>B. J. Blunkett Jr.</i>		PHYSICIAN'S NAME (Type) <i>M.D.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-8-1957</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Calvary Cemetery</i>
22d. LOCATION (City, town, or county) <i>Aberdeen</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Otelia G. Bullock - Harford Grange, Md.</i>		24a. REC'D. BY REGISTRAR <i>Oct 5-57</i>	24b. REGISTRAR'S SIGNATURE <i>Kellie R. Penry</i>

1 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page \_\_\_\_\_ may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please ~~separate~~ carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

OCT 7 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Medical Examiner's Office along with form MM3. Page 1 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10712 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										10720 Reg. Dist. No. 182												
1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Mich</u> b. COUNTY																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethel</u>					c. LENGTH OF STAY IN lb <u>3 days</u>																	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>336 Catherine St</u>					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Detroit</u>																	
f. STREET ADDRESS <u>8051 CAHALAN ST.</u>					g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print)		First <u>Charles</u>	Middle <u>Herbert</u>	Last <u>Lovell</u>	4. DATE OF DEATH <u>October 4</u>	Month	Day	Year	5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 10, 1885</u>	9. AGE (in years last birthday) <u>71</u> yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>					10b. KIND OF INDUSTRY <u>MANUFACTORY</u> <u>TRAIN CONDUCTOR AND INSPECTOR</u>					11. BIRTHPLACE (State or foreign country) <u>LONDON, ENGLAND</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>UNKNOWN</u>					14. MOTHER'S MAIDEN NAME <u>LOVELL</u>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>					16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>S. EVERET LOVELL</u> <u>336 CATHERINE St,</u> <u>BEL AIR, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <u>(b)</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)																	
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)										
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>																						
ACTUAL SIGNATURE <u>Donald C Palmer</u> EXAMINER'S NAME (Type) <u>Donald C Palmer MD</u>										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>												
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT. 8, 1957</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>WOODMERE CEMETERY</u>		22d. LOCATION (City, town, or county) <u>DETROIT</u>		DATE SIGNED <u>10-1-57</u>														
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Foster BROADWAY AND WILLIAMS ST., BEL AIR, MD.</u>				ADDRESS <u>ADDRESS</u>		24a. REC'D BY REGISTRAR <u>DATE 10-5-57</u>		24b. REGISTRAR'S SIGNATURE <u>Porraine L. Lovwood</u>														

RECEIVED  
BUREAU V. S.

OCT 9 1957

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-15 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

10721

10731

**CERTIFICATE OF DEATH**

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY HARFORD CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN RURAL		MARYLAND LENGTH OF STAY (in this place) 14 WEEKS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS  HARFORD CONVALESCENT HOME		STATE MD COUNTY HARFORD CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HAVRE DE GRACE, STREET ADDRESS (If rural give location) 224 N. STOKES ST.	
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE OF DEATH</b> (Month) (Day) (Year)	
WALTER (First) (Middle) (Last)		OCTOBER 7 1957	
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>
MALE	WH	MARRIED	1/11/1884
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	
RETIRED CARPENTER		UNK	
<b>13. FATHER'S NAME</b>		<b>14. MOTHER'S MAIDEN NAME</b>	
William Davis OSBORN		VIRGINIA MITCHELL	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>	
NO		UNK	
<b>17. INFORMANT &amp; ADDRESS</b>		<b>18. MEDICAL CERTIFICATION</b>	
VIRGINIA WILSON R.D. 1, Aberdeen Md.		IMMEDIATE CAUSE (A) Lobar Pneumonia, bilateral, Atypical Hypostatic ANTECEDENT CAUSES (B) DUE TO Terminating Cerebral thrombosis (Oct. 2, 1957) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C) DUE TO STATING UNDERLYING CAUSE LAST, DUE TO Chr. Cardio-Vascular Disease	
		INTERVAL BETWEEN ONSET AND DEATH 5 days	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>		?	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While Not while at work at work	
		21f. HOW DID INJURY OCCUR?	
<b>22. I hereby certify that I attended the deceased from Sept. 23, 1957, to Oct. 8, 1957, that I last saw the deceased alive on Oct. 6, 1957, and that death occurred at 11:40 P.M. from the causes and on the date stated above.</b>		<b>ADDRESS</b> (Street, city, town, state)	
<b>SIGNATURE</b> Willard P. Hudson		<b>DATE SIGNED</b> 10-7-57	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> BURIAL		<b>DATE THEREOF</b> 10/10/57	<b>NAME OF CEMETERY OR CREMATORIUM</b> Forest Hill
		<b>LOCATION</b> (City, town, or county) Maryland	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> Revilla Lovvold	
		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> Pennington & Son Haven Green, Md.	
<b>DATE</b> 10-9-57			

BUREAU N.Y.

OCT 11 1957

REGULIVEL

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10713

## CERTIFICATE OF DEATH

Reg. Dist. No.

1072285-

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY CECI	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		c. LENGTH OF STAY IN 1b 6 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD Memorial Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural	
3. NAME OF DECEASED (Type or print) IRA		First 5 Middle	4. DATE OF DEATH Oct 29 1957
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY Owner	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George H. Poist	
14. MOTHER'S MASTERN NAME Emma a. Nickle		15. WAS DECEASED EVER IN U. S. ARMED FORCES? No	
16. SOCIAL SECURITY NO. 215-24-2509		17. INFORMANT 215 Frank S. Poist, Port Deposit, Md.	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Chronic Myocarditis - 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chv. Nephritis -		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1957 to Oct 29 1957 that I last saw the deceased alive on Oct 29 1957, and that death occurred at 4220 M. from the causes and on the date stated above. ACTUAL SIGNATURE Clarence I. Benson, M.D.			
22a. BURIAL/CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 10-31-1957	22c. NAME OF CEMETERY OR CREMATORIAL West Nottingham
22d. LOCATION (City, town, or county) Colard, Md. Rural		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son, Perryville, Md.		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE G. L. Lewis, M.D.
		DATE 10-31-57	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Part 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU X

NOV 3 1957

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for use as a burial permit.

VS AISC 1-51 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10723

## CERTIFICATE OF DEATH

10714

Reg. Dist. No. 182

<b>1. PLACE OF DEATH</b>			<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>		
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town)	MARYLAND	STATE Maryland	COUNTY Harford		
TOWN Bel Air	LENGTH OF STAY (in this place) 5 Years	TOWN Bel Air	CITY (If outside corporate limits, write RURAL and give nearest town)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS  Harford Convalescent Home	/ STREET ADDRESS	(If rural give location)			
<b>3. NAME OF DECEASED (Type or Print)</b>  Annie M. Purcell			<b>4. DATE (Month) (Day) (Year)</b>  IF DEATH October 10 1957		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	B. DATE OF BIRTH August 2, 1867	9. AGE last birthday 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Lawrence Purcell			14. MOTHER'S MAIDEN NAME Annie Riley		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Dora Johnson, Bel Air, Md.		
<b>18. MEDICAL CERTIFICATION</b>					
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  IMMEDIATE CAUSE (A) Bronchial pneumonia ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Upper respiratory infection GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)					
INTERVAL BETWEEN ONSET AND DEATH 7 days					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>11/15</u> , 1950, to <u>October 10, 1957</u> , that I last saw the deceased alive on <u>October 9, 1957</u> , and that death occurred at <u>10:05 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Willard P. Hudson, M.D.</u> ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>October 11, 1957</u>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1957 October 12	NAME OF CEMETERY OR CREMATORIAL St. Ignatius	LOCATION (City, town, or county) (State) <u>Hickory, Harf. Co., Md.</u>	
24 REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <u>Purcell, L. W. Foster</u> ADDRESS <u>Broadway &amp; Williams Sts. Bel Air, Maryland</u> DATE <u>10-11-57</u>					
25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>Broadway &amp; Williams Sts. Bel Air, Maryland</u>					

BOSTON V. S.

1900

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10715

## CERTIFICATE OF DEATH

10724

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY <i>Hanford</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution or residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Hanford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>		c. LENGTH OF STAY IN 1b <i>111 Baltic Street</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>111 Baltic Street</i>		d. STREET ADDRESS <i>111 Baltic Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Grove Watson Robson</i>		First	Middle	Last	4. DATE OF DEATH Oct 22 1957
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Dec 31 1882</i>	9. AGE (In years last birthday) <i>74 yrs</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self Emp. Carpenter</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>Andrew Robson</i>		14. MOTHER'S MAIDEN NAME <i>Ella Bond</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>214-03-5530</i>		17. INFORMANT <i>Allen B. Robson Aberdeen MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Inanition</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</i> (b)		<i>Cerebral thrombosis</i>		3 months	
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</i> (c)		<i>Cerebral + generalized arteriosclerosis</i>		5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Apr 8</i> , 1957, to <i>Oct 22</i> , 1957, that I last saw the deceased alive on <i>Oct 22</i> , 1957, and that death occurred at <i>10:30 PM</i> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>617 W. Belair Ave</i>	
ACTUAL SIGNATURE <i>B.J. Plunkett Jr. M.D.</i>				DATE SIGNED <i>10-23-57</i>	
PHYSICIAN'S NAME (Type) <i>B.J. Plunkett Jr. M.D.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/24/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Seneca Cemetery</i>		22d. LOCATION (City, town, or county) <i>Stanley New York</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Veter G. Darney Aberdeen Maryland</i>		ADDRESS <i>111 Baltic Street</i>		24a. REC'D BY REGISTRAR DATE <i>Oct 24/57</i>	
				24b. REGISTRAR'S SIGNATURE <i>Nellie R. Perry</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

OCT 28 1957

RECEIVED

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. After this copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this copy has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate should be detached for use as a burial transit permit.

VS A15C 1-5 10K

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 21 Film 222 11-15-57 ams

10725

## CERTIFICATE OF DEATH

10716

Reg. Dist. No. 182

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY HARFORD	MARYLAND	STATE MD	COUNTY HARFORD
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN Bel Air	54 years	TOWN Bel Air	Rural
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS RD 1	(If rural, give location)
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
Rebecca G Ruff		Oct 26 1957	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED; (Specify) Widowed	8. DATE OF BIRTH Feb 1875 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) King George Co Va
Housewife			12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME Ben J.P. Grimes		14. MOTHER'S MAIDEN NAME Rebecca Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) Yes		16. SOCIAL SECURITY NO.	
(If Yes, give yr or dates of service)		17. INFORMANT & ADDRESS Henry Ruff Bel Air MD	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) CARDIO-RESPIRATORY FAILURE			
ANTECEDENT CAUSE(S) DUE TO PULMONARY EDEMA			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) DUE TO SHOCK IN 82 YR OLD CONGESTIVE			
STATING UNDERLYING CAUSE LAST. DUE TO (C) FAILURE PATIENT FROM BROKEN HIP-FR			
INTERVAL BETWEEN ONSET AND DEATH 10 MIN.			
30 MIN			
{ 1 HOUR.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		19a. DATE OF OPERATION	
		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) Home	
21c. WHERE DID INJURY OCCUR? (City or town) Rural Bel Air		(County) Harford (State) Md.	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Oct 26 57 P.M.		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR? fell on bedroom floor - apparently tripped over rug.	
22. I hereby certify that I attended the deceased from....., 19 57, to....., 19 57, that I last saw the deceased alive on....., 19 57, and that death occurred at 11:30 P.M. from the causes and on the date stated above. SIGNATURE <i>J.H. Fidell</i> ADDRESS (Street, city, town, state) <i>Bel Air, Md.</i> DATE SIGNED <i>28 Oct 57</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct 29-57	NAME OF CEMETERY OR CREMATORIAL Walters Meeting House
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Revera L. Lowood	LOCATION (City, town, or county) THOMAS RUN R.R. 1 HARFORD MD
DATE 10-28-57		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joseph J. Fidell Bel Air Md.	

RECEIVED  
BUREAU V. A.

OCT 2 1957

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
EM 2 '57

10717 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10726 18/1

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Horford</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harford</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bell Air</i>	c. LENGTH OF STAY IN Tb <i>4 months</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bell Air</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Country Life Farm</i>	d. STREET ADDRESS <i>Country Life Farm</i>	e. IS RELATIVE ON A FARM YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Charles A. Ryan</i>	First <i>Charles</i>	Middle <i>A.</i>	Last <i>Ryan</i>	4. DATE OF DEATH <i>October 19 1957</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 20, 1891</i>	9. AGE (In years at birthday) <i>65 yrs</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Commodore Merchant Service</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Wisconsin</i>	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Charles Ryan</i>	14. MOTHER'S MAIDEN NAME <i>Agnes Sullivan</i>	Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs. Charles A. Ryan Marylander Apts</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) <i>Carcinoma Lung</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>	Month, Day, Year <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>Gerald C Palmer</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>Bel Air, Md. 10-19-57</i>			
EXAMINER'S NAME (Type) <i>Gerald C Palmer MD</i>	22b. DATE THEREOF <i>10/23/57</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Arlington National Cemetery</i>	22d. LOCATION (City, town, or county) <i>Arlington, Va.</i> (State)	
22a. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	22e. ADDRESS <i>111 Calvert St.</i>	22f. REG'D BY REGISTRAR <i>21 1957</i>	22g. REGISTRAR'S SIGNATURE <i>Franklin Howard</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H W Mease &amp; Son 825 1/2 Calvert St.</i>	ADDRESS <i>111 Calvert St.</i>	DATE <i>21 1957</i>		

BUREAU V. S

OCT 21 1955

MEGEIVEL

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10727

185

10718

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY HARFORD		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)	
				a. STATE Md	b. COUNTY Baltimore-Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harford Yenice		c. LENGTH OF STAY IN 1b 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington-Baltimore Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD Memorial Hospital		d. STREET ADDRESS Plaza Apartments-Lark Wilson		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Florence P		First	Middle	Last	DATE OF DEATH October 19 1957
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov-15-1869	9. AGE (in years last birthday) 87 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? US					
13. FATHER'S NAME George T. Sadler		14. MOTHER'S MAIDEN NAME Ann S. Plitt		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No		16. SOCIAL SECURITY NO. None		17. INFORMANT Ann H. Wilson. Darlington, Md	
(Yes, no, or unknown) (If yes, give war or date of service) No					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 2 hours			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44dx		Cerebrovascular accident			
DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost.		Hyperensive cardiovascular disease			
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rectal polyp		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. -		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 7, 1957, to October 19, 1957, that I last saw the deceased alive on October 19, 1957, and that death occurred at 2:40 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE James McC. Timney M.D. 330 S. UNION AVE, HARVEY GRAY, Md. PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Oct 12/1957		22c. NAME OF CEMETERY OR CREMATORIY Green Mount	
22d. LOCATION (City, town, or county) Baltimore Md				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Stewart Monroe		ADDRESS 10810 North Carrollton		24a. REC'D BY REGISTRAR	
15M 9/55				24b. REGISTRAR'S SIGNATURE B.L. Lewis	
VS A15 (4)				DATE Oct 19, 1957	

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10728

Reg. Dist. No.

185-

10719

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE [Where deceased lived if institution Residence before admission] a. STATE	
HARFORD MARYLAND		Maryland HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
HARFORD DE GAGE	7 HRS 55 MIN	WHITEFORD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
HARFORD Memorial Hospital			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
Laura		Belle	Seymour
4. DATE OF DEATH	Month	Day	Year
OCTOBER	7		1957
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
FEMALE WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 13, 1887	9. AGE (In years lives today)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	—	West Virginia	USA
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
William Reed	Lettie Dolly		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	—	—	ELSIE HARDING, STREET, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
Acute myocardial infarction			
INTERVAL BETWEEN ONSET AND DEATH 3 days			
440.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.			
(b) Coronary Sclerosis			
3 yrs.			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
none			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/6, 1952, to 10/7, 1952, that I last saw the deceased alive on 10/7, 1952, and that death occurred at 2:55 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE		Neil Taylor M.D.	
PHYSICIAN'S NAME (Type)		Rising Sun, Md 10/8/52	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM
BURIAL		10-9-57	SLATE RIDGE
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR DATE 10-9-57
John H. Barkins, Delta, Pa.			24b. REGISTRAR'S SIGNATURE A. L. Henry, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trust permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

OCT 10 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10729

10720

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived) [If institution, Residence before admission] a. STATE <b>Maryland</b> b. COUNTY <b>Harfard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD Memorial Hospital</b>		e. STREET ADDRESS <b>Anthony Estes Silveira</b>		d. STREET ADDRESS <b>1018</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>Anthony</b>	Middle <b>Estes</b>	Surname <b>Silveira</b>	4. DATE OF DEATH <b>October 21 1957</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 31 1897</b>	9. AGE (In years last birthday) <b>60 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chef Business Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Partugal</b>		10c. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Silveira, Anthony S.</b>		14. MOTHER'S MAIDEN NAME <b>Francisca da Gloria Vargas</b>		12. CITIZEN OF WHAT COUNTRY?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-20-7893</b>		17. INFORMANT Address <b>Georgia I. Silveira, Edgewood, Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Hypertensive Cardiovascular Disease</b>		<b>Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED White Not white at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 11th 1957</b> to <b>Oct 21 1957</b> , that I last saw the deceased alive on <b>Oct 21st 1957</b> , and that death occurred at <b>3:00 P.M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>211 N. Union Ave. 10/20/57</b>	
ACTUAL SIGNATURE <b>Edward C. Too, M.D.</b>				DATE SIGNED <b>10/20/57</b>	
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct 24, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Bel Air Memorial Gardens</b>	
22d. LOCATION (City, town, or county) <b>Bel Air</b>		(State) <b>Harford, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. McNamee, Jr.</b>		ADDRESS <b>Abingdon, Md.</b>		24a. RECD BY REGISTRAR DATE <b>10/20/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Dr. G. L. Lewis</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

OCT 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10735 CERTIFICATE OF DEATH

10735  
Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) b. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Madford</i>		c. LENGTH OF STAY IN 1b <i>60 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethel Church</i>	
d. STREET ADDRESS <i>—</i>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>NELSON G. Smith</i>		First <i>N</i>	Middle <i>E</i>
4. DATE OF DEATH <i>Oct 21 1957</i>		Month <i>Oct</i>	Day <i>21</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Oct 13 1884</i>		9. AGE (In years last birthday) <i>73 yrs</i>	10. IF UNDER 1 YEAR Months <i>6</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Janitor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bethel Church</i>	10c. BIRTHPLACE (State or Foreign country) <i>Cockeysville Md</i>
11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		12. FATHER'S NAME <i>Ignatius G. Smith</i>	
13. MOTHER'S MAIDEN NAME <i>Laura Tittle</i>		14. MOTHER'S MAIDEN NAME <i>—</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>not</i>		16. SOCIAL SECURITY NO. <i>212-32-0985A</i>	17. INFORMANT <i>David V. Smith</i>
		Address <i>White Hall Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis, Acute.</i>		3 HR's.	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), listing the underlying cause first (b) <i>Arteriosclerotic - Hypertension HT Disease 10 years.</i>		DUE TO	
(c) <i>Coronary Sclerosis -</i>		10 years.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>None</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>
20f. (City or town) <i>—</i>		(County) <i>—</i> (State) <i>—</i>	
21. I certify that I attended the deceased from <i>8/17/1957</i> to <i>10/16/1957</i> , that I last saw the deceased alive on <i>10/16/1957</i> , and that death occurred on <i>10/16/1957</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Jarrettown, Md</i>	
ACTUAL SIGNATURE <i>S. James Thomison Jr., M.D.</i>		DATE SIGNED <i>10/23/57</i>	
PHYSICIAN'S NAME (Type) <i>S. JAMES THOMISON, Jr., M. D. Jarrettsville, Maryland</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 24 1957</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>—</i>
22d. LOCATION (City, town, or county) <i>Towson Rd Jarrettsville Md</i>		(State) <i>—</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Marie E. Reed, Jarrettsville Md</i>		24a. REC'D BY REGISTRAR <i>—</i>	24b. REC STRA'S SIGNATURE <i>Perilla Lowood</i>
		DATE <i>10-26-57</i>	

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10721 CERTIFICATE OF DEATH

10731  
Reg. Dist. No. 185

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace, Md.		c. LENGTH OF STAY IN 1b Wife	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Norman Tracy Stecher		First	Middle
		Last	Jr.
5. SEX Male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Sept. 21, 1956
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Norman Tracy Stecher		14. MOTHER'S MAIDEN NAME Vivian Burger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO	17. INFORMANT Address Norman T. Stecher, Perryville, Md. R.F.D.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Influenza</i>		INTERVAL BETWEEN ONSET AND DEATH <i>July 2</i>	
1x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Virus pneumonia</i> DUE TO		<i>48 hrs</i>	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>49.2 X</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 24, 1957, to Oct 31, 1957, that I last saw the deceased alive on Oct 31, 1957, and that death occurred at 6:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>H. H. Richards Jr.</i> ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <i>H. H. Richards Jr.</i> DATE SIGNED <i>10-4-57. 100-7-11-57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 11-3-1957		22b. DATE THEREOF <i>11-3-1957</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Hofswell Cemetery</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lew Patterson &amp; Son, Perryville, Md.</i>		ADDRESS	24a. LOCATION (City, town, or county) <i>Perryville, Md.</i> (State) <i>Rural</i>
		24b. REC'D BY REGISTRAR <i>G. L. Lewis M.D.</i>	DATE <i>11-1-57</i>

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10732

## CERTIFICATE OF DEATH

10736

Reg. Dist. No. 182

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. After this copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
CITY <b>Harford</b> TOWN <b>Rocks</b>		STATE <b>Maryland</b> COUNTY <b>Harford</b> CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Rocks</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		LENGTH OF STAY (In this place) <b>2</b>	
		STREET ADDRESS (If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Mary</b>		(First) (Middle) (Last) <b>Josephine Sweeting</b>	
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>Sept. 3, 1869</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Cherry Hill Md.</b>
13. FATHER'S NAME <b>Benjamin Rigdon</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Rigdon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mrs. Mary Bosley Rocks Md.</b>	
<b>18. MEDICAL CERTIFICATION</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <b>(A) Cerebral hemorrhage</b>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) <b>Generalized arteriosclerosis</b>			
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Deafness</b>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 19, 1952, to Oct. 17, 1957, that I last saw the deceased alive on Oct. 15, 1957, and that death occurred at 7 A.M., from the causes and on the date stated above. SIGNATURE <i>Robert Battin</i> M.D. ADDRESS (Street, city, town, state) <b>Forest Hill, Maryland</b> DATE SIGNED <b>10-17-57</b>			
VS AISC 1-55 10M			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	DATE THEREOF <b>Oct 19-57</b>	NAME OF CEMETERY OR CREMATORIAL <b>Emory church</b>	LOCATION (City, town, or county) (State) <b>Emory, Harford, Md.</b>
24. REC'D BY REGISTRAR <b>Priscilla Foword</b>	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Martin Schatz Janet Harford</b>	
DATE <b>10-21-57</b>			

BUREAU V.

1957

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10737

## CERTIFICATE OF DEATH

10733  
Reg. Dist. No. 182

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Harford</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marlington Rural</i>		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marlington Rural</i>		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Alma J. Thompson</i>		First <i>J.</i>	Middle <i>A.</i>	Last <i>Thompson</i>	4. DATE OF DEATH <i>Oct. 15, 1957</i>	Month <i>Oct.</i>	Day <i>15</i>	Year <i>1957</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <i>Widowed</i>	8. DATE OF BIRTH <i>May 15, 1903</i>	9. AGE (In years (last b'day) yrs. <i>54</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Hours <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter/gauevenwark</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (State or foreign country) <i>Garrison Co., Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Geo. Thompson</i>		14. MOTHER'S MARRIED NAME <i>Matilda Frasier</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give name, date of service) <i>No</i>		16. SOCIAL SECURITY NO <i>018-18-1012</i>		17. INFORMANT <i>Mrs. Leonard Thompson</i>		Address <i></i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>332x</i>		DUE TO <i>Cerebral thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 wks</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>Arterio-sclerotic CVD</i>		(c) <i>Arterio-sclerotic CVD</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 yrs</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>Sept 19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>Churchville Md</i>		
21. I certify that I attended the deceased from <i>Sept</i> , 19 <i>57</i> , to <i>Oct</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>Oct 5</i> , 19 <i>57</i> , and that death occurred at <i>1 P.M.</i> from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>J. Ralph Hertk</i>		ADDRESS (Street, city or town, state) <i>Churchville Md</i>						DATE SIGNED <i>Oct 18</i>
PHYSICIAN'S NAME (Type) <i>J. Ralph Hertk MD</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Oct. 10, 1957</i>		22b. DATE THEREOF <i>Oct. 10, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Bell-Air Memorial Park, Harford Co., Md.</i>		22d. LOCATION (City, town or county) (State) <i>Harford Co., Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. S. Bailey Marlington, Md.</i>		ADDRESS <i>H. S. Bailey Marlington, Md.</i>		24a. RECEIVED BY REGISTRAR DATE <i>Oct. 9, 1957</i>		24b. REGISTRAR'S SIGNATURE <i>C. H. Flirk</i>		

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RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10734

Reg. Dist. No. 185

FOR STATE  
HEALTH DEPT.

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10722

If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be given as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Harford</b>		2 USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hayre de Grace</b>		b. COUNTY <b>Hayre de Grace</b>	
c. LENGTH OF STAY IN 1b <b>8 mo</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dot Harford Mem. Hospt</b>		d. STREET ADDRESS <b>R.D. 1</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Thomas Tibbs</b>		4. DATE OF DEATH Month <b>October</b> Day <b>11</b> Year <b>1957</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>20 April 1949</b>	
9. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. AGE (In years from birthday) <b>8 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
10c. BIRTHPLACE (State or foreign country) <b>Maryland</b>		11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>J. Robert Tibbs Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Mildred Walter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <b>No</b>		16. SOCIAL SECURITY NO <b>*** *** ***</b>	
17. INFORMANT <b>J. Robert Tibbs Sr.</b>		Address <b>R.D. 1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>G.S.W. Chest</b> <b>919.0</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Md.</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>(b)</b>			
DUE TO <b>(c)</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <b>Accidentally shot by brother</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>5 p.m.</b> 10-11 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b> 20f. (City or town) <b>Hanover</b> (County) <b>Md.</b> (State) <b>154 N. Kedbridge</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Gerald E Palmer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>Baltimore, Md.</b> DATE SIGNED <b>10-12-57</b>	
EXAMINER'S NAME (Type) <b>Gerald E Palmer, MD</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 10/15/57		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Zion</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G Barron</b>		22d. LOCATION (City, town, or county) <b>R.B. Bel Air, Md.</b> (State)	
ADDRESS <b>Aberdeen, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 10-15-57</b> 24b. REGISTRAR'S SIGNATURE <b>G. J. Deacon</b>	
VS ATSM FM 2/57			

BUREAU V.

OCT 17 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10735

## CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH o COUNTY <b>Harford</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Harford</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		c. LENGTH OF STAY IN lb <b>5 Yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b>		d. STREET ADDRESS <b>g. E. Cedar Drive</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US Army Hospital Aberdeen Proving Ground</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>JOHN</b>		First	Middle	Last	4. DATE OF DEATH <b>October 30 1957</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cau</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>30 Oct 57</b>	9. AGE (In years lost birthday) yrs. <b>2</b>	IF UNDER 1 YEAR Months <b>2</b>	IF UNDER 24 HRS. Days <b>25</b>	Hours <b>2</b>	Min. <b>25</b>
10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired) <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>				
13. FATHER'S NAME <b>Ralph Frank Tropea</b>		14. MOTHER'S MAIDEN NAME <b>Shizuko Hara</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mother (Same as in 2)</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature Birth</b>						INTERVAL BETWEEN ONSET AND DEATH <b>—</b>		
X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO  (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>US ARMY HOSPITAL ABERDEEN PROVING GROUND, Md</b>		(County) <b>ABERDEEN PROVING GROUND, Md</b>		(State) <b>Md</b>
21. I certify that I attended the deceased from <b>30 October 1957</b> to <b>30 Oct 1957</b> , that I last saw the deceased alive on <b>30 October 1957</b> , and that death occurred at <b>2145 M</b> , from the causes and on the date stated above.								
MEDICAL CERTIFICATION PHYSICIAN'S NAME (Type) <b>JOSEPH M SILVERSTEIN CAPT MC</b>				ADDRESS (Street, city or town, state) <b>US ARMY HOSPITAL ABERDEEN PROVING GROUND, Md</b>		DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/4/57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>A.C.C Post Cemetery</b>		22d. LOCATION (City, town, or county) <b>Army Chemical Center, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Farren</b>		ADDRESS <b>Garrison Md</b>		24a. REC'D BY REGISTRAR <b>Dow 2-57</b>		24b. REGISTRAR'S SIGNATURE <b>Hillie R. Henry</b>		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DUANE V. S.  
NOV - 2001  
MCGEIVY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

10723

10736/185  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY	Harford	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE Md.	b. COUNTY Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Havre de Grace	D.O.A.			Havre de Grace
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS

HARFORD MEMORIAL

3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

October

18 (19) 1957

e. IS RE-DL-1 F  
ON A FARM?  
YES  NO

5. SEX F 6. COLOR OR RACE W 7. MARRIED  NEVER MARRIED  8. DATE OF BIRTH  
WIDOWED  DIVORCED  Aug 14 - 1957 27 days

9. AGE (In years  
last birthday)  
Months Days Hours M.M.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY

12. COUNTRY (State or foreign country)

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

771.0

DUE TO

Pulmonary hemorrhage

INTERVAL BETWEEN  
ONSET AND DEATH

Conditions, if any, which  
gave rise to immediate cause  
(a), stating the underlying  
cause last.

(b)

DUE TO

(c)

unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO

20a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING  CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a. m. p. m.

20d. INJURY OCCURRED  
While at work  Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held on Autopsy , Inspection , Inquiry , and in my opinion death resulted from: Natural causes  Accident , Suicide , Homicide , Undetermined manner

ACTUAL  
SIGNATURE

Gerald E Palmer

M.D. CHIEF MEDICAL EXAMINER

DATE SIGNED  
10-19-57

EXAMINER'S  
NAME (Type)

Gerald E Palmer M.D.

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

10-20-1957

Elston Cemetery

Elston Cemetery

Md

ADDRESS

Joseph P Grant

North East, Md

Dr. J. Lewis

Dr. J. Lewis

DATE

JCT 21/10/57

REG'D. BY REGISTRAR

REGISTRAR'S SIGNATURE

DATE

DATE

V.S. A15

BUREAU V. S.

OCT 22 1957

REGISTRY

*Handwritten Signature*  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1 ME  
DM 2 57

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18** **10739** **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** **10737**

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Pa</i> b. COUNTY <i>Philadelphia</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Alexandria</i>		c. LENGTH OF STAY IN 1b <i>1 day</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Salvage Area AP&amp;R</i>		d. STREET ADDRESS <i>131 May St. 110</i>	
3. NAME OF DECEASED (Type or print) <i>Ralph E. George Wolf</i>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. SEX <i>Male</i> COLOR OR RACE <i>White</i>		5. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 6. DATE OF BIRTH <i>Nov 18 1926</i>	
7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (in years from birthday) <i>30 yrs</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Serf Yester</i>	
10c. BIRTHPLACE (State or foreign country) <i>Penns.</i>		11. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Lev. Wolfe</i>	
14. MOTHER'S MAIDEN NAME <i>Mary K. Wolf</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes 1945 1947</i>	
16. SOCIAL SECURITY NO. <i>163-22-0349</i>		17. INFORMANT <i>Raymond Wolf-</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Crushing injury chest</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>910.5</i>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
DUE TO (c) <i></i>		21. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Part of side craft he was driving fell off him</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>3 p.m.</i> 10-15 1957		20d. INJURY OCCURRED <i>While at work</i> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Salvage Area AP&amp;R Harford Md</i>	
20f. (City or town) <i></i>		20g. (County) <i></i>	
20h. (State) <i></i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. ACTUAL SIGNATURE <i>Gerald C. Palmer</i> DATE SIGNED <i>Bel Air, MD 10-10-1957</i>	
EXAMINER'S NAME (Type) <i>Gerald C. Palmer M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>10/19/57</i>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Cedar Hill Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Fredricksburg Penna</i>		(State) <i>Penna</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Carrigan Oberleben Maryland</i>		24a. REC'D BY REGISTRAR <i>Attn: Mrs. D. Perry</i> DATE <i>Oct 7 1957</i> 24b. REGISTRAR'S SIGNATURE <i>D. Perry</i>	

RECEIVED  
BUREAU V. S.

OCT 15 1957

1

FOR STATE  
HEALTH DEPT.MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10738

Reg. Dist. No. 18d

10724

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>		c. LENGTH OF STAY IN lb <b>20 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Emmorton Rd 29</b>		e. STREET ADDRESS <b>Emmerton Road</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>M. Ward</b>	Middle <b>Filmore</b>	Last <b>Wright</b>
4. DATE OF DEATH	Month <b>October</b>	Day <b>30</b>	Year <b>1957</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 27 - 1863</b>
9. AGE (In years last birthday) <b>93</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HR. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Springfield Ill</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Robert J Wright</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Perkins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>mm Sadie W. Stephenson</b>	
17. INFORMANT <b>Bel Air, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>904.0</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
Conditions, if any, which gave rise to immediate cause (a), starting the underlying cause lost. <b>b) Bruise skull</b>		DUE TO (b) <b>Cerebral Oedema</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell + struck head</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>10-16 1957</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Bel Air, Harford Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Gerald C Palmer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Gerald C Palmer MD</b>		DATE SIGNED <b>10-30-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-1-57</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>St Mary's Episcopal</b>		22d. LOCATION (City, town, or county) <b>Emmerton Harford, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph J Foster Bel Air, Md.</b>		24a. REC'D BY REGISTRAR <b>Busilla Lourard</b>	
ADDRESS <b>10-31-57</b>		24b. REGISTRAR'S SIGNATURE <b>Busilla Lourard</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU N.Y.  
RECEIVED

NOV 4 1957

STATE OF NEW YORK - DIVISION OF STATE PLANNING  
EXAMINING BOARD OF DATA

STATE  
DATA

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10739  
185

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**CERTIFICATE OF DEATH**

Reg. Dist. No. \_\_\_\_\_

1. PLACE OF DEATH o. COUNTY <b>HARFORD</b>		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] o. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PLACE DE GROOE</b>	c. LENGTH OF STAY IN 1b <b>3 Mo.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FALLSTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>Box 116</b>	
3. NAME OF DECEASED (Type or print) <b>FRANCES</b>	First <b>A.</b>	Middle <b>WYKES</b>	Last <b>OCTOBER 7 1957</b>
4. DATE OF DEATH <b>OCTOBER 7 1957</b>	Month <b>Oct</b>	Day <b>7</b>	Year <b>1957</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 19, 1876</b>
9. AGE (In years from last birthday) <b>80</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
13. FATHER'S NAME <b>MORRIS RUSSELL</b>	14. MOTHER'S MAIDEN NAME <b>Honoree RUSSELL</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs. Jane Harvey, Fallston, Md.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <b>Coronary occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Odell</b>	20f. (City or town) (County) (State) <b>Baltimore</b>
21. I certify that I attended the deceased from <b>10-5</b> , 19 <b>57</b> , to <b>10-7</b> , 19 <b>57</b> that I last saw the deceased alive on <b>10-5</b> , 19 <b>57</b> , and that death occurred at <b>12:10 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Gerald C Palmer</b>	M.D.	ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Gerald C Palmer</b>	DATE SIGNED <b>10-7-57</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct 10, 1957</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Odell Protestant</b>	22d. LOCATION (City, town, or county) (State) <b>Odell Illinois</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Archer, Benson</b>	ADDRESS <b>10078</b>	24a. REC'D BY REGISTRAR DATE <b>10-7-8 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Dr. J. L. Lewis</b>

STATE GOVERNMENT OF HAWAII - DIVISION OF  
CENSUS AND STATE RECORDS

CHIEF CATE OF DEATH

BUREAU V. S.

OCT 8 1957

RECEIVED